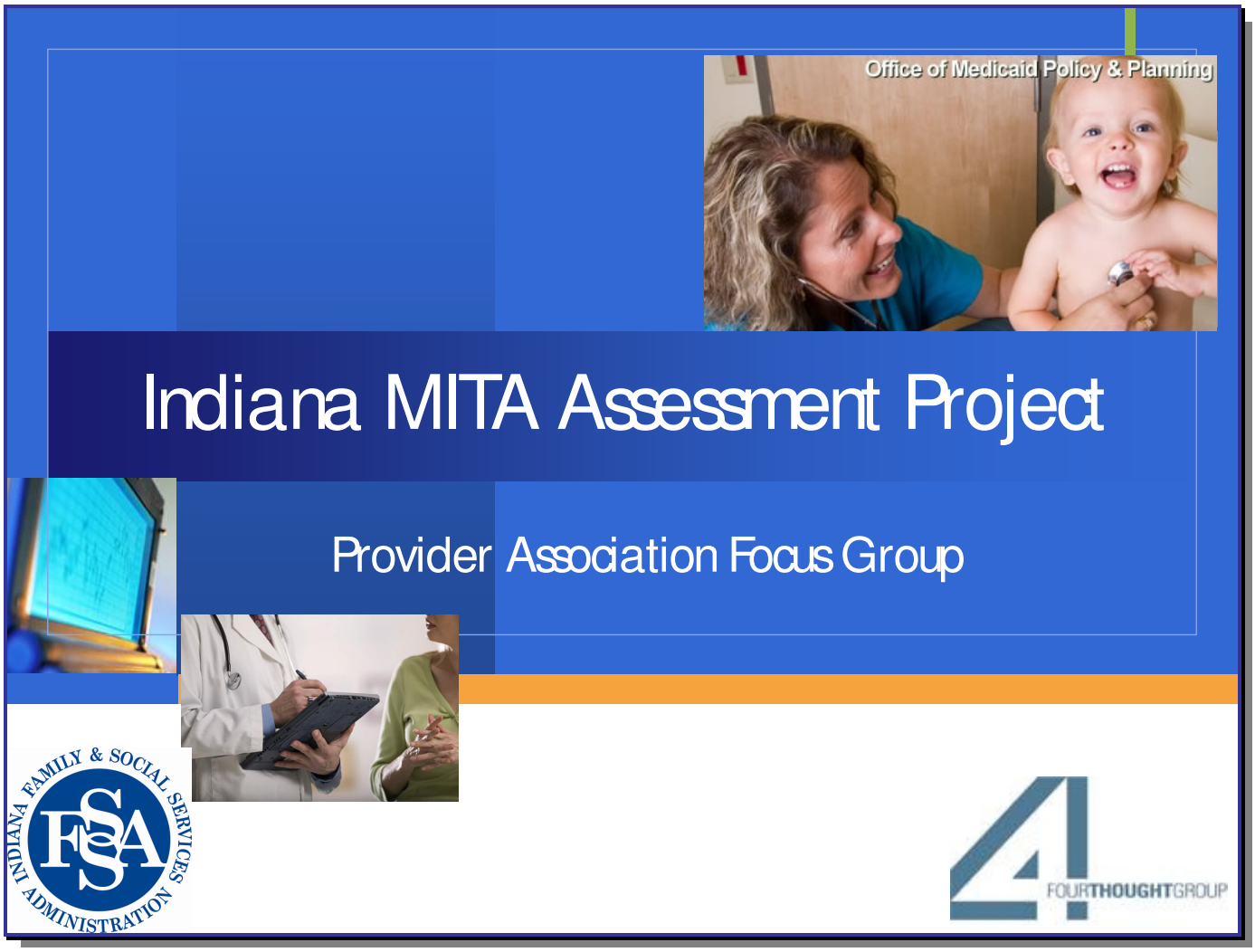

Indiana Family & Social Services Administration

Medicaid Information Technology Architecture Assessment Project

INDIANA PROVIDER ASSOCIATION FOCUS GROUP DELIVERABLE

VERSION 5.0

FOURTHOUGHT GROUP

AUGUST, 2008

Revision History

The following table records the revision history of this document.

VERSION	DATE	AUTHOR	COMMENTS
1.0	06.01.08	M. Reneé Bostick	Original Draft
2.0	06.04.08	M. Reneé Bostick	Crowe, Randy Miller and Jeff Wells
3.0	07.14.08	Wade Miller	Additional Comments from OMPP PM staff
4.0	07.29.08	M. Reneé Bostick	Additional comments from Crowe, Randy Miller and Jeff Wells
5.0	08.05.08	M. Reneé Bostick	Additional comments from Jeff Wells

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Executive Summary

The Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) hired FourThought Group (4TG) to assist them in conducting a Medicaid Information Technology Architecture (MITA) Assessment. MITA, an initiative of the Center for Medicare and Medicaid Services (CMS), is a plan to promote improvements in the Medicaid enterprise and the systems that support it through collaboration between CMS and the States. The MITA Assessment provides the opportunity to assess the State's current Medicaid business processes and capabilities, as well as determine the State's target capabilities and future goals.

As a part of the Indiana MITA Assessment project, OMPP and 4TG led a Provider Association Focus Group Session to allow Indiana provider associations to discuss the challenges faced today serving the Indiana Medicaid population and to propose areas that OMPP should focus on improving to enable them to provide value-driven healthcare to Hoosiers.

The purpose of this document is to summarize feedback and findings from that session.

To gain the most representative provider perspective, broad participation was sought from twenty (20) different Indiana Provider Associations. Fourteen (14) representatives from eleven (11) Provider Associations participated in the Focus Group. Also, ten (10) surveys were completed and returned by representatives from the Provider Associations to provide addition input.

The representatives were invited to provide input on the Medicaid Enterprise Envisioned Future, as well as feedback on the Enterprise's current performance of selected business processes and future priorities for performance improvement. As Jeffrey Wells, M.D., OMPP Director, summarized at the conclusion of the Focus Group meeting, providers offered clear feedback that the MITA Member Processes, specifically focusing on Eligibility and Enrollment, are the key priority for performance improvement in the short term.

Providers offered support for the Envisioned Future through their agreement with the strategic long term vision. Providers communicated clear support for

the Envisioned Future, and that addressing some of the immediate concerns with Eligibility and Enrollment is essential for providers to redirect their energies toward a brighter future described in the Envisioned Future deliverable.

Purpose

The purpose of the Indiana MITA Assessment Project ***Provider Association Focus Group Deliverable*** is to involve providers and advocates as key stakeholders and participants in the definition of success for the Medicaid Enterprise. Providers and advocates play a critical role in improving health outcomes, health care delivery and population health.

Recognizing the importance of providers and advocates, OMPP Director, Jeffrey Wells, M.D., broadened the scope of the Indiana MITA Assessment Project to ensure the voices of providers and advocates are present in the refinement of the Envisioned Future, in the assessment of the current capabilities of the Medicaid Enterprise, and in prioritization of future initiatives and target capabilities along the strategic *"Line of Sight."*

Information from the Provider Association meeting will be integrated into the following deliverables of the State of Indiana MITA Assessment project.

1. ***Current Capabilities Assessment*** – the collection, review and assessment of the capability maturity level of business processes of the current Medicaid Enterprise

2. ***Target Capabilities Assessment*** – the analysis of the future vision and priorities of the Medicaid Enterprise to establish and document the target capability maturity levels required of the future Medicaid Enterprise to achieve the Envisioned Future

3. ***Transition and Implementation Plan*** – a high-level transition strategy and priority project portfolio needed to close the gap between the current and target capabilities and realize the future vision

Approach

Prior to the Focus Group meeting, which was held on May 20, 2008, 4TG provided meeting materials to enable Provider representatives to understand the meeting purpose and be better prepared to participate in the dialogue. Participants were provided a summary description of the MITA Assessment project, the current draft of the Indiana Medicaid Health Care Envisioned Future, the Focus Group agenda, and the MITA Business Process survey tailored for provider input. Provider Association representatives were asked to complete the survey prior to the meeting to solicit their input on the current state of the performance of the Medicaid Enterprise in the following MITA Business Areas: Member, Provider, Operations and Care Management.

At the Focus Group, Dr. Wells and M. Reneé Bostick, from 4TG, provided an overview of MITA, the Indiana MITA Assessment Project and the Medicaid Enterprise Envisioned Future or long term vision. After the overview, 4TG facilitated the session, which was designed to engage participants in a dialogue about and provide feedback on the Medicaid vision, current process performance and future performance improvement targets.

This document provides a synopsis of providers' comments on the vision, the current and future process capabilities that were provided during the session, as well as written responses to survey questions that were returned prior to, during, and after the Focus Group. The group's feedback will be used as key input into the assessment of the Indiana Medicaid Enterprise's current state, future state and plan to close gaps in between these two states.

Provider Association Focus Group Findings

The Findings section of the document summarizes the feedback from Provider Association and Member Advocate representatives (herein referenced as the Provider Association Focus Group) obtained through two approaches – survey and Focus Group session. The survey was sent to the Provider Association and Member Advocate Focus Group as a part of their meeting invitation materials with a request to return the completed survey prior to the meeting.

This section summarizes findings for the following three areas where feedback was sought and received:

1. Medicaid Health Care Envisioned Future

2. Current Business Process Performance, and

3. Future Performance Improvement Areas.

INDIANA MEDICAID HEALTH CARE ENVISIONED FUTURE

This section summarizes the feedback received from Provider Association representatives during the Provider Association Focus Group regarding the Indiana Medicaid Health Care Envisioned Future. This part of the Focus Group began with Dr. Wells presenting an overview of the Envision Future, and 4TG facilitating the dialogue and feedback. The Provider representative comments below are listed in the four perspectives for the Envisioned Future of the Medicaid system from four key perspectives – Member, Provider, Stakeholder and Vendor perspectives.

Overall, providers concurred with the strategic vision, but expressed a number of concerns and issues that must be addressed in the short term in order for providers to be able to redirect their attention and support towards the achievement of the Envisioned Future.

In 2005, FSSA recognized significant challenges and limitations with its current eligibility system and made decision to update technology by entering into ten (10) year, $1.16 billion dollar contract with an IBM led Hoosier Coalition for Self-Sufficiency of vendors, including Affiliated Computer Services (ACS), Alpha Rae Personnel, Crowe Chizek and Co., Haverstick Consulting, Interactive Intelligence, Phoenix Data, RCR Technology and Arbor Education and Training ("Coalition"). As described in the *Eligibility Modernization: The Need for Change* report by Erin Linville in 2006, the FSSA Intake Process was "cumbersome, slow, ineffective, and highly prone to errors [resulting in] dissatisfied customers, ineffective welfare reform, inappropriate delays, unmanageable caseloads, inconsistent application of rules, regulations and policies and fraud."

This project began a four phase roll out process in August 2007 and has been implemented in over half of the State. The goal is to improve customer service through an eligibility application system that is available 24 hours a day, seven days a week supported by interactive phone system and the Internet. Technology is to supplement, not replace, the process of personally meeting a caseworker in a county office. The project allows people who want or need in-person support from a caseworker to apply for services the opportunity to do so, while also making available other means supported by technology to improve the eligibility and enrollment process.

Member Perspective Feedback

Key elements of the Provider Association feedback focused on the following:

1. ***Streamline Eligibility Processes*** – Family members and caregivers for seniors and persons with disabilities expressed concerns about the current state of the eligibility system roll out. They reported that while the solution likely works for many Medicaid applicants, there are important special challenges faced by persons who are most vulnerable with special needs, such as persons with disabilities or who are elderly. They indicated reports of difficulties in tracking down documentation and meeting with eligibility workers during the work week. Few can afford to take off work to address the complicated eligibility process. Both advocates and providers expressed concerns that often the same information has to be reproduced during

disability determinations, and for many again at re-determination. Many individuals covered by Medicaid are dependent on providers and care managers to get into the correct program and access needed care, and many providers indicated that this need will continue in the future. Providers recognized that Member Management Eligibility and Enrollment services need to be designed to address the needs of the majority of covered groups, and that specialized services must be tailored and available to address specialized member needs.

1.1.1. The group believes that the current application and eligibility roll out process still needs further simplification and streamlining, especially for certain populations. In their experience, the current application and process seems to be an amalgamation of several programs with bureaucratic and confusing language. In their Envisioned Future, Case Managers would place additional emphasis on allowing, encouraging, and supporting applicants with initial eligibility determination and re-determination processes. While they support a range of options from the "high tech" options, they think additional focus needs to be placed on the needs of individuals and their representatives who still need "high touch" support to use automated processes. They suggested that web applications need to be interactive, clearly conveying to clients in simple language what is asked, what is needed and how to provide the information. The system needs to guide individuals through the process, tolerate and correct errors, provide redirection and guidance, as well as the capability to automatically connect the applicant with customer service to assist the individual through the application process, if they require or request additional assistance.

1.1.2. Similar changes were envisioned in the eligibility re-determination process. Providers and advocates strongly recommended eliminating unnecessary and duplicative requests for documentation. Providers cited examples of repeated requests for copies of documentation, such as tax returns from previous years, which had already been submitted during the initial application for benefits. In the future, there should not be lost documentation, repeated requests, and providers should be allowed to act as an "authorized

representative" for members who need assistance, particularly providers of facility-based care.

2. ***Need for Third Party ("Authorized Representative") Assistance to Act on Behalf of the Individual***– Providers and advocates cited a number of examples where individuals, due to age, disability or reading level, required assistance to successfully complete the eligibility determination or re-determination process or to locate and access care. Comments focused on the need for authorized representatives, such as family members, as well as care givers and facility staff, since many individuals do not have involved family members, to be designated as a representative to assist individuals through this process.

3. ***Ensure Seamless Connection between Health Care and Social Services*** – Unlike traditional covered populations, many within the Medicaid coverage groups require basic social services, such as housing, nutrition and economic support in order to benefit from health care services. Thus, it is important that the Medicaid Enterprise within FSSA focus on the health of the whole person and provide a seamless connection with other social services that impact the clients overall health. People who are homeless, are in an unsafe or unhealthy environment, or are without adequate nutrition are more likely to experience more negative health events. Providers urged that the vision needs to acknowledge the whole spectrum of related services necessary to promote and sustain health.

4. ***Provide Medical Home for Members of the Indiana Medicaid Enterprise*** – Numerous attendees provided feedback that the Envisioned Future is a positive direction and suggests many best practices, except it should include the concept of "Medical Home." Providers felt strongly that the Envisioned Future of care should include a "Medical home" for all members that manages and coordinates care based on individualized needs. Programs such as Care Select were referred to as a move in the right direction by providing clinicians with a consolidated view of each member's medication which helps to improve care for members and promote the notion of a team of professionals supporting care of individuals across services and agency boundaries. To advance this concept, providers indicated that there will also need to be changes to barriers that may be present at the Federal level.

5. ***Address Accessibility Needs of Diverse Medicaid Population*** – participants stressed that there is no "one-size-fits-all" solution for a coverage population that is as diverse as the Indiana Medicaid Program and has as many unique and significant care needs. Much of the Envisioned Future focuses on technology as a key enabler of access, information and care. However, many within the coverage population, including seniors and persons with development disabilities and/or behavioral health care needs, have challenges with current eligibility systems and information requirements, and will continue to need personalized assistance through the eligibility, care and re-determination processes. Additionally, many citizens who have low income have limited or no access to telephones, Automated Voice Response systems or web-enabled systems through the Internet. Representatives stressed the need for FSSA to continue, if not expand, the capability to provide "high touch," not just "high tech" solutions

6. ***Provide Transparent and Easily Accessible Information for Members through a Variety of Means*** – Many participants indicated that often members are not aware of their own eligibility status. Like most health care consumers, members of a Medicaid health plan have challenges in understanding eligibility status, plan coverage and status, as well as financial and personal responsibilities. For many people these areas are challenging to comprehend in the best of times, and next to impossible when the individual or a family member is amidst a health crisis. Providers stressed the need to solicit feedback from members on the best ways to ensure essential health information is transparent and easily accessible.

   Additionally, providers agreed that Electronic Health Records (EHR's) and Personal Health Records (PHR's) are integral parts of the Envisioned Future. EHR's and PHR's would assist providers, families and individuals in working together to coordinate care, particularly in such situations as transfers to long term care (LTC) or rehabilitation facilities following hospitalization. These points of change in care providers would benefit from immediate access to information about earlier treatment, changes in medication, and continuity of care. Providers of LTC services indicated that they would need assistance, guidance and direction in transitioning to this new environment, and in selecting EHR and PHR systems that will be compatible with State and Federal guidelines or requirements.

7. ***Clarify and Streamline Care Management Responsibilities*** – Providers indicated that for covered populations, such as persons with developmental disabilities, there appears to be both overlap and gaps in Care Management role functions. Providers indicated that they and their clients are not always clear where responsibilities begin and end for clients who may have a Case Manager, a Care Manager and a guardian. There were questions as to who was responsible for making decisions on such matters as "What is best for the client? How much money should be spent on care? How much should be spent on Case Management to perform activities of daily living? In the envisioned future, Providers stressed the need for greater clarity and coordination between such case management functions to ensure that all needed services are provided without duplication.

Dr. Wells summarized the feedback by stressing three key points:

1. FSSA needs to be attentive to the diverse needs of persons receiving their health care coverage through Medicaid, particularly when planning for changes and improvements in business process and information technology systems. Even more than other health plans, Medicaid solutions are not "one size fits all".
2. FSSA will get better health outcomes when members are more engaged in their healthcare. We should promote personal responsibility to those members who can self manage.
3. FSSA should not lose sight of processes outside of Medicaid that effect Medicaid processes or services, such as waiting lists for services for persons with development disabilities.

Provider Perspective Feedback

Regarding the Provider Perspective of the Envisioned Future, Focus Group participants offered the following feedback:

1. ***Streamline the Provider Enrollment and Credentialing Processes*** – Providers agreed that significant time and energy is wasted on multiple enrollment and credentialing processes. They recommended that providers should complete a single application and information should be shared electronically to

support enrollment and credentialing for participation in all Indiana Health Care Plans (IHCP), including health plans, HMO's, CMO's, as well as across FSSA divisions and other relevant portions of State government. The process should be transparent enabling a provider to know where they are in the enrollment and credentialing process.

2. ***Increase Physician and Provider Participation in the Medicaid program*** – Providers indicated that increased participation would be directly connected to the effort spent in creating efficient, effective and streamlined process and systems support for providers. They indicated that physicians would be more willing to treat individuals eligible for Medicaid, if they were assured that individuals would be determined and re-determined eligible in a timely and efficient process, and they would be assured of timely reimbursement.

3. ***Increased Transparency*** – Providers need timely, accurate and available information to provide Value Driven Health Care. Providers and the members they serve need to know or have the capability to easily access information about:

   3.1. Member eligibility status including knowing where the application is currently located within the determination/re-determination process,
   3.2. The member's current medications, allergies and what medications are covered by their plan,
   3.3. Where to access services to prevent the use of emergency room services in non-emergent situations, and
   3.4. The actual costs of care as well as the rate of provider reimbursement.

4. ***EHR and PHR Adoption and Expansion*** – Focus Group participants agreed with the need for greater adoption of EHR's and PHR's, and that the Medicaid Enterprise needs to support and guide the effort for adoption and acceptance. Physicians were clear that EHR's must "fit seamlessly into the overall physicians or providers practice." EHR adoption will be slowed, if not stalled, if these systems require physicians to take extra steps beyond what they must do today. Physicians are already taxed by time consuming, cumbersome processes that do not add to patient care. Also the group indicated that similar changes must occur simultaneously at the Federal level for these efforts to be successful. Just as it is essential for divisions within FSSA to work together, offices within the U.S. Department of Health and

Human Services, including Health Resources Services Administration (HRSA) and CMS need to co-ordinate quality reporting standards and efforts.

Stakeholder Perspective Feedback

With regard to the Stakeholder Perspective in the Envisioned Future, the Focus Group offered the following feedback:

1. ***Streamline Constituent Helpline Processes*** – Participants agreed with this area of the vision. Constituents need to be able to call anywhere with the Medicaid Enterprise and have the staff member be able to access information about their issue. Many providers acknowledged that it is hard to coordinate information across such a large organization, but critical for stakeholders to not feel pushed from one area to the next and have to continually repeat their concern to the next staff member. Timely, accurate and coordinated communications are important elements of good customer service.

2. ***Provide Transparent Program Information*** – Providers agreed with the envisioned changes increasing the availability of program information through electronic means. While increasing the amount of information in electronic format on the web, providers encouraged the enterprise to review and revise its requirements that all reports must be in printed paper copies for reviews or audits. Many times this information is printed only for the audit and then thrown away. Electronic storage and access is easier and more cost effective.

3. ***Make Cost and Quality Information Accessible*** – Providers indicated that both raw data as well as formatted information would be helpful and useful in their practices. Providers are interested in seeing information on:

    3.1. Actual cost of care,
    3.2. Reimbursement rates by service and level of care,
    3.3. Per member per month costs across health care programs, and
    3.4. Capitation rates.

Dr. Wells inquired whether providers would also like access to the following data: Cost Projections, Budget Data, Expenditure Data, Budget to Actual Data, and Quality of Care data. Providers concurred and indicated that this information should also be accessible for Members of the health plan and their families who might start to re-examine care based on costs.

4. ***Streamline Quality Reporting Processes*** – For providers that serve individuals with health care coverage from several different health plans, the reporting requirements are onerous and, at times, even contradictory. The lack of standard quality measures and reporting infrastructure is costly, inefficient and ineffective, and it was suggested that the Medicaid Enterprise adopt industry standard quality measures and reporting processing, regardless of provider type.

Current Business Process Feedback

To obtain feedback on Indiana Medicaid's current business processes (described in the section), and the future performance improvement areas (addressed in the next section), 4TG developed and analyzed the results from the Provider Association Business Process Survey, and facilitated discussion during the Provider Association Focus Group. Comments obtained from both of these sources are summarized in these two sections.

In order to understand providers' perspective of the current state of the Medicaid Enterprise business process performance, 4TG identified four MITA Business Areas that have the most relationship with providers. From the Member, Provider, Operations and Care Management Business Areas, 4TG selected those business processes which involve providers and structured a series of questions based on MITA capability maturity characteristics to assess providers' perspective on how well the Indiana Medicaid Enterprise currently performs these processes. For each business process selected, providers were asked three types of questions:

1. What processes work well in today's environment?
2. What processes do not work well?
3. What are the barriers, if any, are preventing effective delivery of health care services?

Member Management Business Process Feedback

In the Member Management Business Area, providers were asked to rate "How timely, accurate, efficient, effective is the Medicaid Enterprise Business Process" for the following four processes:

1. Determine Eligibility,
2. Enroll Member,
3. Disenroll Member
4. Inquire Member Eligibility.

In addition, we asked how providers access information about the process and the value they place on this process.

Overall, providers rated the performance of these processes low with an average score of 2 (out of 5), and the value of these processes as high with an average score of 5 (out of 5).

Member eligibility and enrollment processes received the most negative feedback, while indicating that these processes are of vital importance to members and providers alike. Providers reported experiencing the following barriers in the eligibility process:

- Significant delays in the eligibility determination process, including delays of up to 7 months to determine eligibility for pregnant women, and up to 6 to 7 months for persons in long term care and rehabilitation facilities,
- Repeated requests for the same information and lost applications, which may negatively impact service date,
- Clients have been unable to access the Internet application,
- Telephone calls placed on hold for long periods, or frequently transferred from staff to staff without complete and accurate responses,
- Long delays in the re-determination process,
- Members who lack the capability without family or authorized representatives to assist in the completion of eligibility application or re-determination process; a particular challenge for skilled nursing (SNF's) and rehabilitation facilities who cannot obtain information or coverage for seniors or persons with disabilities in their care, and
- Lack of specialized assistance for persons with behavioral health care needs.

While a majority of the providers had significant concerns with the eligibility processes, few had issues with the current Member Eligibility Verification process. Most providers reported that eligibility verification is timely and reliable, while a few had problems with verification accuracy. This was particularly true with regard to third party coverage, such as Medicare and private payers.

During the Provider Association Focus Group, we asked providers three additional questions in the Member Management area that were not included in the survey that was distributed prior to the meeting. These questions,

structured in a similar format, were presented during the Focus Group to gain provider insight on how timely, accurate, efficient, effective are the Medicaid Enterprise Business Processes relating to Value Driven Health Care, such as:

1. ***Transparency*** – The group as a whole indicated that current business processes do not provide transparency. Providers indicated there is currently not any transparency into processes or information such as actual cost of care, member health outcomes, or total cost to the Medicaid program.

2. ***Education and Outreach*** – Providers stated that member education and outreach is inadequate to meet the needs of members, providers and the Medicaid Enterprise. Most of the education and outreach performed today is conducted by providers without reimbursement or support.

   A few providers acknowledged that the primary provider of training is EDS; however that training is focused on provider compliance, rather than member education. Some of the information presented by EDS is then adopted and adapted by providers to inform members and their families of changes in the system.

3. ***Customer Service*** – Providers had few comments in this area, other than the Medicaid Enterprise does not provide effective customer service. They related stories of members who were passed from entity to entity within the Medicaid Enterprise when attempting to get resolution to their issues.

Provider Management Business Process Feedback

The Focus Group reviewed and responded to questions regarding the status of Provider Management Business Processes. The 3 questions in this MITA Business Area focused on:

- Enroll Provider
- Credential Provider, and
- Disenroll Provider.

Overall, providers rated Provider Management process performance as a 3 out of 5, and of significant value to recruiting and retaining physicians and a quality provider network. At least one Association representative stated that timely, accurate, efficient and effective provider enrollment is "the most important issue facing Medicaid."

1. ***Enroll Provider*** – As referenced in the vision dialogue above, providers reported that the enrollment process is cumbersome, burdensome, redundant and duplicative stretching across FSSA Divisions, and multiple vendors, including EDS and MCO's. Each process appears to be separate and distinct, requiring providers to submit many different applications and forms multiple times. This redundancy costs time, money, and serves as a disincentive from participation in the program for many qualified providers.

2. ***Credential Providers*** – Providers' comments were similar to those provided for the "Enroll Provider" process. Rather than streamlining applications and processes, each entity in the process asks the same or similar information, and conducts a wholly separate review process that is burdensome, redundant, costly and frustrating[1].

3. ***Disenroll Provider*** – This process was described as "next to impossible" to disenroll from the program, even when a provider has retired or died. The disenroll process also crosses boundaries of more than one vendor, thus complicating the process. EDS cannot disenroll some providers without coordinating efforts with MCO's. Each division or vendor manages only their own part of the process, and disenrollment is not viewed as a high incident event warranting cross enterprise collaboration.

   Some suggested that the Medicaid Enterprise needs to create a separate inactive provider file. Without addressing this issue, it becomes very difficult to address the adequacy of a provider network, as there is no way to distinguish active from inactive (or unwilling to accept new patients) providers. This further frustrates members who have to call multiple providers to determine who is active and may be accepting new clients.

[1] The Healthcare Administrative Simplification coalition estimates that these types of separate and distinct credentialing processes cost an average of **$809** per physician per year for a projected total of **$485 million** per year in the United States.

Operations Management Business Process Feedback

Focus Group members reviewed the Operations Management questions and provided the following feedback:

1. ***Authorize Service*** – Providers reported problems with timely authorization for dental and behavioral health care services. They also indicated that it is often difficult to obtain adequate authorization from MCO's for necessary services for members. Standards are not clear, policies change frequently and there are few opportunities for provider education. Each MCO appears to have its own structure and process making it difficult for providers to track. Surgical procedures are the most difficult authorizations to obtain and are not provided timely.

2. ***Edit/Audit Claims or Encounters*** – Some providers, mainly MCO's, reported difficulties with getting payment adjustments for inaccurate payments, and a lack of consistency in interpretation and application of auditing standards.

3. ***Price Claims / Value Encounters*** – Few comments were offered on this process, however, LTC facilities reported that this process works well and is accurate.

4. ***Prepare Remittance*** – Based on feedback this appeared to be one of the more efficient processes. Providers indicated that EDS is more efficient in this area than are the MCO's. Dental claims appeared to have the most difficulty in receiving correct information on why payments were rejected or suspended.

5. ***Inquire Payment Status*** – According to provider feedback, most providers did not report problems with this process. Some indicated that MCO's do not consistently provide timely and accurate payment status information and others stated that EDS's performance was reported as adequate. Focus Group and survey responses revealed that physicians' concerns primarily focus on reimbursement. They described reimbursement as slow due to holds or suspended claims, and reimbursement rates that are too low to

support timely access and quality care requirements that are expected of them.

Care Management Business Process Feedback

During the Focus Group, providers offered few comments on the Care Management Business Processes, and the survey responses focused mostly on Medicaid waiver concerns.

1. ***Establish Case*** – no comments.

2. ***Manage Case*** – Providers indicated that this process did not exist for most members. Care Select was referenced as the primary program supported by this business process and most providers did not have enough experience with this program to report on the performance of the process.

3. ***Manage Medicaid Population Health*** – Providers report that this process is not performed in the current Medicaid Enterprise.

4. ***Manage Registry*** – The Medicaid Enterprise needs to standardize its registries to share a common set of data elements to support research, reporting and provider feedback.

Future Performance Improvement Areas

The Provider Association survey and Focus Group allowed the Medicaid Enterprise the opportunity to learn directly from key Provider Association leaders about their perspectives on the Medicaid Enterprise Envisioned Future, current business process performance and priorities for performance improvement. Although many diverse perspectives were presented throughout the session, feedback clearly evidenced the need for performance improvement in several select areas including:

1. Eligibility determination and redetermination
2. Provider Enrollment and Credentialing
3. Claims Payment Processes – particularly focusing on payment adjustments., and
4. Transparency in multiple areas, including tracking eligibility, enrollment, data, statistics, quality & cost of care, and details around service authorizations.

These four key areas are currently providing the most problems for providers and member advocates and should be prioritized as items for performance improvement by FSSA.

Through the discussion of the Medicaid Enterprise vision it was clear that providers supported the strategic direction. They are as interested in and committed to the provision of quality care, as they are sensitive to the unique needs of the individuals covered by the Medicaid plan. Accordingly, providers recommended that the future vision include a "high touch" as well as "high tech" strategy to include and enfranchise those who need and can benefit from quality health care.

Although the discussion of current business process performance surfaced a number of areas that are ripe for improvement, providers were clear and in agreement on the need for substantive performance improvement in the Eligibility and Enrollment -- MITA Member Management – business process area. The prominence of concerns over these processes made it clear that this is the prime target for performance improvement in the short term. Even

though some of the issues identified by providers may be longstanding concerns, this does not diminish the need for a timely, accurate, efficient and effective Member Eligibility process as a fundamental capability of the Medicaid Enterprise. In fact, it appears essential that the Medicaid enterprise capabilities must improve to gain the necessary provider buy-in and commitment for future envisioned changes.

4TG Observations and Analysis

4TG applauds FSSA for requesting feedback from the provider associations and member advocate groups related to both current performance of business processes and future plans and vision of the Indiana Medicaid enterprise. The focus group was engaged and participatory in the meeting and provided valuable feedback on current challenges in providing care to Indiana Medicaid members. Additionally, the group had several suggestions for consideration for immediate improvement in the current processes as well as provided comment and suggestions on the planned vision.

One of the core challenges facing the Medicaid enterprise in improving the maturity of their business process capabilities is the issue that Secretary Roob identified early in this project – fragmentation. The purpose of the MITA Assessment is to enable a State Medicaid program to chart its course of improvement across the Medicaid Enterprise operations and outcomes. CMS defines the Medicaid enterprise as (1) those domains covered by Federal matching funds, (2) the interfaces and bridges across Medicaid stakeholders, including providers, members and Federal State and local agencies and payers, as well as the (3) national health information communities, commissions and initiatives. MITA seeks to foster ***integrated*** business and IT transformation across divisions, sectors, silos and services through an end-to-end process view of the enterprise. Providers comments echoed throughout this report illustrate the magnitude of this challenge. Each division, office, program and vendor is responsible for their part. At present these "parts" do not constitute a whole and seamless process.

While the Medicaid Enterprise will need to improve process capabilities in other areas that are traditionally ranked as priority provider concerns, Eligibility is the primary provider concern. Additional areas to focus on process improvement include Provider Management processes such as Enrollment and Credentialing, and Operations Management payment processes.

4TG suggests that FSSA and OMPP utilize the MITA Current Capability Assessment to identify business processes assessed at lower MITA maturity levels within the business areas identified by the Provider Association Focus

Group to begin process improvement activities. Related business processes may then be grouped into a "project" for prioritization consideration by OMPP and FSSA. The project may be as simple as improving coordination and collaboration within the Indiana Medicaid Enterprise or may end up being a combination of business process improvement and automation improvement. An immediate recommendation is that FSSA may want to consider, as mentioned in the meeting, engaging the provider association focus group (or similar group) again specifically to discuss issues brought up in the meeting related to authorized representatives acting on behalf of members for eligibility determination and redetermination.

As a final suggestion, FSSA may want to convene this group on a regular basis, possibly quarterly, to discuss current events, issues, and proposed changes to the Indiana Medicaid program. While the Provider Association Focus group appeared to be interested in working with FSSA on identifying and solving problems, FSSA has not committed to such a regular forum but may seek other ways to solicit feedback.

The Provider Association Focus Group was a positive first step in seeing and understanding the enterprise from a provider process perspective. Now it will be important for the Medicaid enterprise to take the next action steps in addressing these concerns.

Next Steps

Dr. Wells brought the Provider Association Focus Group to a close by thanking representatives for their active interest and participation. He appreciated the feedback and the issues raised to ensure the Medicaid Enterprise addresses the full range of needs of its current and potential members. He stated that he and his staff would be reviewing the comments with a specific focus on how to ensure the right levels of high tech and high touch focus into the future, ways to make services and information more transparent, and streamline redundant or cumbersome processes for greater efficiency and effectiveness.

He heard providers clearly state that their primary concerns is with the Eligibility determination and re-determination processes. Dr. Wells acknowledged that these issues need to be addressed as quickly as possible, and he appreciated their honesty and forthrightness. These issues need to be addressed in the short term to build the shared commitment to change necessary to realize the Medicaid Enterprise's Envisioned Future.

The top three Major concerns raised during the meeting included:

1. The need to correct the problems associated with eligibility determination and redeterminations.

2. The inability of authorized representatives to assist members with the eligibility determination process.

3. The need to streamline the provider enrollment process across the entire Medicaid enterprise such that providers are not required to complete applications and credentialing materials more than once.

Suggested next steps for OMPP to consider, regarding immediate action include:

1. FSSA to convene a group to review and consider recommendations to alter the requirements for an authorized representative to address the providers concerns related to allowing authorized representatives to assist clients or act on their behalf during eligibility determination or

redetermination process. Many providers agreed and signified interest in meeting before the legislative session to work through issues together.

2. Review any examples of problems provided by the group of current eligibility determination (or redetermination) cases and determine if there are possible immediate fixes that can be instituted within FSSA and their eligibility determination vendor(s).
3. Review the "Enroll Provider" process, as a part of the MITA Current Capabilities deliverable development, and identify possible changes to the process at the Medicaid Enterprise level that would alleviate provider concerns raised during the Focus group meeting.

Appendix A. Provider Association Focus Group Participants

Provider Association	Invitees	Organizational Representative Attended
1. ARC of Indiana	John Dickerson, Executive Director	
2. Behavioral Health Management, Inc.,	Sandy Kauffman, President	X
3. Hoosier Owners & Providers for the Elderly (HOPE)	Sheri Hampton	X
4. Indiana Association of Area Agencies on Aging	Melissa Durr, CEO	X
5. Indiana Academy of Family Physicians	Allison Matters, Director of Legislative & Regional Affairs	X
6. Indiana Association of Homes and Services for the Aging	Jim Leich, President	
7. , Indiana Academy of Ophthalmology, Inc	Maureen Hoffmeyer, Assoc Executive Director	
8. Indiana Council of Community Mental Health Centers	Matthew Brooks, Executive Director	X
9. Indiana Dental Association	Ed Popcheff, Director of Governmental Affairs	X
10. Indiana Hospital Association	Doug Leonard, President Allison Wharry, VP, Regulation/Policy	X
11. Indiana Health Care Association	Todd Shellenberger, CFO	
12. Indiana Health Information Exchange	Marc Overhage, CEO	
13., Indiana Association of Rehabilitation Facilities	Jim Hammond, President/CEO Kim Opshal, VP, External Affairs	X
14. Indiana Primary Health	Lisa Winternheimer, President & CEO	X

	Care Association		
15.	Indiana Radiology Business Management Association	Linda Wilgus, Officer	
16.	Indiana Rural Health Association	Don Kelso, Executive Director	
17.	Indiana State Medical Association	Lawrence McCormack, Director of Governmental Relations Shelly Symmes, CME Coordinator	X
18.	Mental Health America of Indiana	Stephen McCaffrey, President and CEO Tiffany D. Peek. Exec Asst to President	
19.	National Alliance on Mental Illness Indiana	Pamela McConey, Executive Director	X
20.	National Federation of the Blind	Ron Brown, President	